DEPARTMI **320-01**

38 CFR Part 17

RIN 2900-AR01

VA Pilot Program on Graduate Medical Education and Residency

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs proposes to revise its medical regulations to establish a new pilot program on graduate medical education and residency, as required by section 403 of the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Network Act of 2018.

DATES: Comments must be received on or before **[insert date 60 days after the date of publication in the FEDERAL REGISTER].**

ADDRESSES: Comments may be submitted through www.Regulations.gov or mailed to, Paul B. Greenberg, Deputy Chief, Office of Academic Affiliations, (14AA), Department of Veterans Affairs, 810 Vermont Ave., NW., Washington, DC 20420. Comments should indicate that they are submitted in response to “RIN 2900-AR01 – VA Pilot Program on Graduate Medical Education and Residency.” Comments received will be available at regulations.gov for public viewing, inspection or copies.

FOR FURTHER INFORMATION CONTACT: Paul B. Greenberg, Deputy Chief, Office of Academic Affiliations, (14AA), Department of Veterans Affairs, 810 Vermont Ave.,

NW., Washington, DC 20420, (202) 461-9490. (This is not a toll-free telephone number.)

SUPPLEMENTARY INFORMATION: Section 403 of the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Network Act of 2018 (Public Law 115-182, hereafter referred to as the MISSION Act) mandated the Department of Veterans Affairs (VA) create a pilot program to establish additional medical residency positions authorized under section 7302 of title 38 United States Code (U.S.C.) (note to 38 U.S.C. 7302) at certain covered facilities. This proposed rule would establish substantive and procedural requirements to allow VA to administer this pilot program in a manner consistent with section 403 of the MISSION Act.

Section 7302(e)(1) of title 38 United States Code (U.S.C.) permits VA to both establish medical residency programs in VA facilities and ensure that such established programs have a sufficient number of residents. Section 403 of the MISSION Act created a note to section 7302 to expand VA's authority to establish medical residency positions in covered facilities to include non-VA facilities such as health care facilities of the Department of Defense and Indian Health Service. Section 403 of the MISSION Act further provides parameters for VA to determine those covered facilities in which residents will be placed. For instance, section 403 requires VA to consider certain factors to determine whether there is a clinical need for providers in areas where residents would be placed. Section 403 also requires prioritized placement of residents under the pilot program in Indian Health Service facilities, Indian tribal or tribal organization facilities, certain underserved VA facilities, or other covered facilities. Section 403 additionally authorizes VA to pay resident stipends and benefits regardless of whether such residents are assigned to a VA facility, and requires VA to pay certain

startup costs of new residency programs (such as curriculum development and faculty salaries) if residents are placed in such programs under the pilot program. The authority for the pilot was initially scheduled to expire on August 7, 2024; however, it was subsequently extended to August 7, 2031, under section 5107 of Public Law 116-169.

Before detailing the regulations we propose to implement this mandated pilot program, we provide a brief summary of VA's administration of its Graduate Medical Education (GME) programming under 38 U.S.C. 7302(e), to establish a basic understanding of VA's understand of the conduct of GME programming in general. Under section 7302(e)(1), VA establishes new medical residency programs in VA facilities and ensures that such programs have a sufficient number of residents; VA also ensures that existing medical residency programs have a sufficient number of residents. Criteria under sections 7302(e)(1)(A)-(B) and (e)(2)(A)-(B) further guide VA's selection of its facilities in which residency programs will be established or residents will be placed, where such criteria relate to VA staffing levels, location of VA facilities in certain areas deemed as health professional shortage areas, and priority for residents to be placed for the provision of specific types of health care. Through a request for proposal (RFP) mechanism, VA Central Office notifies VA facilities of these selection criteria as well as other parameters. This RFP details, among other things: consideration factors to be assessed by VA Central Office (as well as the relative importance or weight of such factors); information required from VA facilities to be in any response to the RFP submitted back to VA Central Office; and the process to submit a response to the RFP, to include submission instructions and timelines for completion. Upon receipt of those RFP responses submitted by VA health care facilities, VA Central Office evaluates the responses submitted against the criteria in the RFP to determine those facilities in which residents will be placed or whether funding will be made available for certain costs of

establishing new medical residency programs. In administering GME programming under section 7302(e), VA forms relationships with non-VA institutions that sponsor graduate medical educational programs (most often medical schools or teaching hospitals), and it is those sponsoring institutions that provide the residents that would be available for placement in VA facilities. VA, therefore, does not control the pool of participating educational programs or available residents, although VA does assess the requirements under section 7302(e) to determine the best placement for such residents in VA facilities. VA in effect then does not place residents but does provide for resident positions to be filled in VA facilities. Under section 7302(d), VA forms academic affiliations with sponsoring institutions to delineate the responsibilities regarding the training of the residents, and VA enters into other separate agreements to control funding of both certain residency program educational costs (such as accreditation fees and National Resident Match Program fees) and the costs of paying resident stipends and benefits. VA envisions that the pilot program authorized under section 403 would be conducted under the same basic tenets of GME programming as presented above, such that there would be agreements formed with academic affiliations with sponsoring institutions and the covered facilities recognized in section 403 and in which residents would be placed under the pilot. We will note throughout these proposed regulations where we expect there to be administrative and substantive similarities and differences between VA's statutory GME programming under 38 U.S.C. 7302 and the pilot program required by section 403.

We propose to establish several new regulation sections in part 17 of title 38 Code of Federal regulation (CFR) in §§ 17.243 through 17.248 to implement this mandated pilot program, as further discussed below.

§ 17.243, Purpose and scope.

Proposed § 17.243(a) would establish that proposed §§ 17.243 through 17.248 would implement the VA Pilot Program on Graduate Medical Education and Residency (PPGMER) to place residents in existing or new residency programs in covered facilities and to reimburse certain costs associated with establishing new residency programs in covered facilities, as authorized by section 403 of Public Law 115-182. Proposed § 17.243(b) would establish the scope of the PPGMER by stating that §§ 17.243 through 17.248 would apply only to the PPGMER as authorized under section 403 of Public Law 115-182, and not to VA's more general administration of GME programs in VA facilities as authorized under 38 U.S.C. 7302(e). Establishing the scope of the PPGMER as separate from VA's more general GME programming under 38 U.S.C. 7302(e) would be necessary because the PPGMER is a time-limited pilot program that will sunset on August 7, 2031 (unless statutorily reauthorized or made permanent), and because section 403 of the MISSION Act establishes PPGMER-specific criteria that do not otherwise apply to VA's administration of GME programs under 38 U.S.C. 7302(e). Additionally, although the PPGMER would be a separately administered program under these proposed regulations, the PPGMER would utilize some of the same administrative concepts or procedures as VA uses to administer programs under 38 U.S.C. 7302(e). For instance, some definitions as proposed in these regulations may be the same as established in certain VA policy used to administer GME programming under section 7302(e), as will be explained in discussion of proposed § 17.244. Proposed § 17.243 would not state the 2031 sunset date of the PPGMER, as the authority for PPGMER may be extended or made permanent in the future. If the authority for PPGMER were not extended or made permanent, VA would cease to implement the PPGMER and would issue a publication in the Federal Register to remove and reserve the regulation.

§ 17.244, Definitions.

Proposed § 17.244 would establish definitions to apply to the PPGMER under proposed §§ 17.243 through 17.249.

The term benefit would be defined to mean a benefit provided by VA to a resident that has monetary value in addition to a resident's stipend, which may include but not be limited to health insurance, life insurance, worker's compensation, disability insurance, Federal Insurance Contributions Act (FICA) taxes, and retirement contributions. We believe this would be a commonly understood definition of this term as it is consistent with the characterization of benefits in VA policy that is used to administer programs under the authority of 38 U.S.C. 7302(e). This definition would be relevant as VA would pay benefits to residents as applicable, as explained later in the discussion of proposed § 17.248.

The term covered facility would be defined to mean any facility identified in § 17.245, as that section is proposed and discussed later in this rulemaking. We would define covered facility in relation to proposed § 17.245, to avoid having to reference § 17.245 in every instance in which the term covered facility would be used in the proposed regulation text.

The term educational activities would be defined to mean all activities in which residents participate to meet educational goals or curriculum requirements of a residency program, to include but not be limited to: clinical duties; attendance in didactic sessions; research; attendance at VA facility committee meetings; scholarly activities that are part of an accredited training program; and approved educational details. We believe this would be a commonly understood definition of this term as it is consistent with the characterization of existing educational activities in VA policy (see, e.g., Veterans Health Administration (VHA) Directive 1400.09, Education of Physicians and Dentists) that is used to administer programs under the authority of 38 U.S.C. 7302(e).

This term would be relevant as it would be used to qualify those stipend and benefits payments VA may make for residents under the PPGMER, as explained later in the discussion of proposed § 17.248.

The term resident would be defined to mean physician trainees engaged in post-graduate specialty or subspecialty residency programs that are either accredited by the Accreditation Council for Graduate Medical Education or in the application process for accreditation. The term resident would further be defined to include individuals in their first post-graduate year (PGY-1) of training (often referred to as Interns), and individuals who have completed training in their primary specialty and continue training in a subspecialty graduate medical education program and (generally referred to as Fellows). These Fellows would often be PGY-4 and above, depending upon the specialty. This term is relevant as it would be used throughout these proposed regulations, and we believe this proposed definition would be commonly understood as it is consistent with the characterization of a resident in VA policy that is used to administer programs under the authority of 38 U.S.C. 7302(e). Because this definition would require the residency programs to be accredited or in the process for such accreditation by the Accreditation Council of Graduate Medical Education, VA would not consider individuals in non-accreditable programs, including VA Advanced Fellows or post-training chief residents, as residents under this pilot. While section 7302(e) uses the term residency position, for purposes of this proposed rule, we propose to use the term resident because that was the term used in sections 403(a)(4) through (6) and (b) of the MISSION Act. Additionally, the proposed definition of resident would permit VA to consider more than one resident as occupying a single resident position (such as a split assignment, which VA would track according to the percentage of VA assigned educational activities).

The term stipend would be defined to mean the annual salary paid by VA for a resident. We believe this proposed definition would be commonly understood as it is consistent with the characterization of a stipend in VA policy that is used to administer programs under the authority of 38 U.S.C. 7302(e). This definition would be relevant as VA would pay stipends to residents as applicable, as explained later in the discussion of proposed § 17.248.

The term VA health care facility would be defined to mean any VA-owned or VA-operated location where VA physicians provide care to Veterans, to include but not be limited to a VA medical center, independent outpatient clinic, domiciliary, nursing home (community living center), residential treatment program, and community-based clinic. This definition would be relevant to characterize one type of covered facility under proposed § 17.245, and relevant to characterize one assessment criterion under proposed § 17.246(a)(7). We believe this definition is reasonable because it would capture the VA settings in which a VA physician provides care to Veterans, as it would be physicians who are teaching residents to be placed under the PPGMER.

§ 17.245 Covered facilities.

Proposed § 17.245 would list the covered facilities in which residents may be placed under the PPGMER, consistent with section 403(a)(2) of the MISSION Act. We would restate the list of covered facilities from section 403(a)(2), versus merely cross-referencing section 403 or the statutory note to 38 U.S.C. 7302, for clarity and to provide regulatory citations that characterize or define certain terms related to covered facilities as applicable. Listing the facility types versus cross referencing section 403 would also allow proposed § 17.245 to include applicable regulatory citations. For instance, section 403(a)(2)(B) establishes that one type of covered facility are those health care facilities operated by an Indian tribe or tribal organization as those terms are

defined in 25 U.S.C. 5304; proposed § 17.245(b) would restate this language from section 403 and would add the relevant regulatory citations for the definitions of Indian tribe and tribal organization.

Proposed § 17.245 would establish the following types of facilities as covered facilities under the PPGMER, consistent with section 403(a)(2) of the MISSION Act: (1) a VA health care facility as defined in § 17.244; (2) a health care facility operated by an Indian tribe or tribal organization, as those terms are defined in 25 U.S.C. 5304 and at 25 CFR 273.106; (3) a health care facility operated by the Indian Health Service; (4) a federally-qualified health center as defined in 42 U.S.C. 1396d(l)(2)(B); (5) a health care facility operated by the Department of Defense; or (6) other health care facilities deemed appropriate by VA. We note that although a VA health care facility is listed as a covered facility under section 403(a)(2)(A) and would also be listed as a covered facility in proposed § 17.245(a), we do not anticipate the PPGMER being a vehicle for the placement of residents in VA facilities, as VA intends to continue operating its GME programming to place residents in VA facilities as authorized under 38 U.S.C. 7302 and 7406, separate from the PPGMER for the duration in which the PPGMER is implemented. We believe the authority under section 7302 is sufficient to place residents in VA facilities. However, we would not want to exclude from this proposed rule an express type of covered facility as listed in section 403(a)(2) of the MISSION Act. Similarly, proposed § 17.245(f) would provide, consistent with section 403(a)(2)(F), that a covered facility could be any other health care facility as VA considers appropriate, giving VA the ability to place residents in a variety of facilities, such as those recognized by the Department of Health and Human Services as Rural Health Clinics, without curtailing the discretion provided to VA by section 403(a)(2)(F) in the administration of the PPGMER.

§ 17.246, Consideration factors for placement of residents

Proposed § 17.246 would establish factors that VA would consider when determining in which covered facilities residents would be placed under the pilot. Consistent with section 403(a)(4)(A)-(G) of the MISSION Act, proposed § 17.246(a)(1) through (7) would generally provide that VA would evaluate these factors in the context of whether there is a clinical need for providers in the area in which a covered facility is located. Proposed paragraphs (a)(1) through (7) would then restate from section 403(a)(4)(A)-(G) the specific factors VA must consider when determining whether there is a clinical need for providers in an area (those specific factors are discussed in detail further in this section of the preamble). We note that these proposed factors, consistent with section 403(a)(4), would not be weighted in any particular manner in the regulation text under proposed § 17.246(a), to allow flexibility for VA to consider the relative import of factors throughout the duration of the pilot. Although these factors would not be weighted in regulatory text, it may be the case that VA would assign levels of relative importance to these factors as part of its selection process, as discussed in the section of this preamble related to proposed §17.247. Additionally, only one factor in proposed paragraphs (a)(1) through (7) would be required to be met for VA to determine that a covered facility would be in an area with a clinical need for providers. As discussed below, it may be the case that some covered facilities could be considered to meet the same factor under paragraphs (a)(1) through (7) of proposed § 17.246, and that additional factors would need to be considered.

Before discussing the specific factors that VA would consider in proposed § 17.246(a)(1) through (7) to determine the clinical need for providers in an area, we clarify that VA would not be soliciting the interest of covered facilities to participate in the PPGMER through a public funding announcement, a public request for proposal, or by establishing an public application process, because section 403 of the MISSION Act is

not an express grant or cooperative agreement authority through which VA may offer a public funding opportunity. Further, section 403 does not authorize any amount of money to be appropriated to implement the PPGMER, separate from VA's administration of its existing GME programing authorized under 38 U.S.C. 7302 and 7406. Because VA does not interpret that section 403 of the MISSION Act to authorize a public funding opportunity for which covered facilities may apply or submit a proposal to be considered, VA would not conduct a public solicitation. Rather, the parameters of VA's selection process for covered facilities would be established in proposed § 17.247, as discussed later in this proposed rule.

Consistent with section 403(a)(4)(A) of the MISSION Act, proposed § 17.246(a)(1) would establish that VA would evaluate the ratio of veterans to VA providers for a standardized geographic area surrounding a covered facility, including a separate ratio for general practitioners and specialists. Proposed § 17.246(a)(1)(i) would establish that VA considers a standardized geographic area to mean the county in which a covered facility is located. We believe this is a reasonable interpretation of a standardized geographic area by which to compare ratios of veterans to VA providers, as most covered facilities as well as VA should be able to access such data. We understand that proposing to use a county as the standardized geographic area would mean that covered facilities in the same county would have the same ratios of veterans to VA providers, making such facilities incomparable in terms of this consideration factor. We reiterate, therefore, that this is only one of multiple factors that VA would consider when determining the need for clinical providers in an area, and we do not anticipate that this factor would prevent covered facilities in the same county from being considered, provided other factors that indicate clinical need are met. Proposed § 17.246(a)(1)(ii) would clarify that when deciding the clinical need for providers in an area, VA may consider either or both of the ratio(s) for general practitioners and

specialists, where a higher ratio of veterans to VA providers would indicate a higher need for health care providers in an area. We believe these clarifications would be consistent with section 403(a)(4)(A).

Consistent with section 403(a)(4)(B) of the MISSION Act, proposed § 17.246(a)(2) would establish that VA would evaluate the range of clinical specialties of VA and non-VA providers for a standardized geographic area surrounding a covered facility, where the presence of fewer clinical specialties indicates a higher need for health care providers in an area, which we believe is a reasonable interpretation of section 403(a)(4)(B) to reflect a commonplace understanding that fewer types of providers in an area can indicate a greater clinical need. Proposed § 17.246(a)(2) would consider the range of specialties of both VA and non-VA providers in an area because section 403(a)(4)(B) is not specific to only VA providers. We note that the term standardized geographic area as used in proposed § 17.246(a)(2) would mean the county in which a covered facility is located, consistent with how that term is defined in proposed § 17.246(a)(1)(i).

Consistent with section 403(a)(4)(C) of the MISSION Act, proposed § 17.246(a)(3) would establish that VA would evaluate whether the specialty of a provider is included in the most recent staffing shortage determination by VA under 38 U.S.C. 7412. Under section 7412(a), not later than September 30 of each year, the Inspector General of VA shall determine, certain clinical and nonclinical occupations for which there are the largest staffing shortages with respect to each VA medical center of the Department. The type of providers considered under proposed § 17.246(a)(3) would be based on the list developed pursuant to 38 U.S.C. 7412(a). We note that the list developed pursuant to 38 U.S.C. 7412(a) is a national list (based on data from all VA medical centers in the country related to shortages of providers), and that this factor would not be evaluated in relation to provider types or numbers at any one VA facility.

We also note that a covered facility would not similarly have to have a shortage of the type of provider on the list developed pursuant to 38 U.S.C. 7412, as it may be that a sufficient number of such providers at a covered facility could indicate the best conditions in which VA should place residents (as these would be the very types of providers VA needs more of). We would not regulate this factor more specifically, however, to provide VA the flexibility in assessing the list developed pursuant to 38 U.S.C. 7412.

Consistent with section 403(a)(4)(D) of the MISSION Act, proposed § 17.246(a)(4) would establish that VA would evaluate whether a covered facility is located in the local community of a VA facility that has been designated by VA as an underserved facility pursuant to criteria developed under section 401 of Public Law 115-182. We note that section 403(a)(4)(D) of the MISSION Act would require VA to consider whether the local community is designated as underserved pursuant to criteria developed under section 401 of Public Law 115-182. Section 401 of Public Law 115-182 relates to VA's criteria to designate its facilities as underserved, rather than communities at large. To clarify any potential inconsistency between the reference to underserved VA facilities in section 401 and underserved communities in section 403, we believe a reasonable reading of section 403(a)(4)(D) provides for VA to consider whether covered facilities are located in a local community in which a VA facility has been designated as underserved under section 401. In developing the criteria to identify underserved VA facilities under section 401, VA must consider various factors, including the ratio of veterans to VA health care providers in an area, the range of clinical specialties offered, whether the local community is medically underserved, data on open consults, whether the facility is meeting the wait-time goals of the Department, and such other factors that VA considers important in determining which facilities are not adequately serving area veterans. For purposes of this factor, if a covered facility is

located in the same Veterans Integrated Service Network (VISN) as a VA facility designated as underserved pursuant to section 401, then VA would consider that covered facility to be located in the same local community as the VA facility. We believe the service area of a VISN would allow VA to consider a broad range of covered facilities, but we would not regulate that requirement more specifically in the event that VA facility service area names change in the future. Using the phrase local community in proposed § 17.246(a)(4) would also be consistent with section 403(a)(4)(D) of the MISSION Act, and would allow VA the flexibility to consider a service area that is different from a VISN in the future, in which case VA would clearly indicate a different standard in the request for proposal that is sent to VA health care facilities for consideration. Lastly, we note that under section 401, a VA facility is characterized as a medical center, ambulatory care facility, and a community-based outpatient clinic. Proposed § 17.246(a)(4) would reference VA facility to be consistent with section 401.

Consistent with section 403(a)(4)(E) of the MISSION Act, proposed § 17.246(a)(5) would establish that VA would evaluate whether the covered facility is located in a community designated by the Secretary of Health and Human Services (HHS) as a health professional shortage area under 42 U.S.C. 254e. Under 42 U.S.C. 254e(a)(1), a health professional shortage is an area in an urban or rural area that has been determined to have a provider shortage and which is not reasonably accessible to an adequately served area, a population group that has been determined to have such a shortage, or a public or nonprofit private medical facility or other public facility that has been determined to have such a shortage.

Consistent with section 403(a)(4)(F) of the MISSION Act, proposed § 17.246(a)(6) would establish that VA would evaluate whether the covered facility is in a rural or remote area. Proposed paragraph (a)(6)(i) would further interpret a rural area to mean those areas identified by the U.S. Census Bureau as rural. Section 403 does not

specifically define or characterize the meaning of the term rural, and therefore, we believe it is rational to use the definition provided by the U.S. Census Bureau. The Census Bureau's classification of rural consists of all territory, population, and housing units located outside of urbanized areas and urban clusters. Interested parties are referred to the Census Bureau's website (https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html) for additional information. Proposed paragraph (a)(6)(ii) would further interpret a remote area to mean an area within a zip-code designated as a frontier and remote area (FAR) code by the Economic Research Service within the United States Department of Agriculture, based on the most recent decennial census and to include all identified FAR code levels. VA would adopt this characterization of a remote area because it does not have a similarly comprehensive characterization of remote areas in statute or regulation. As we are unsure of the level of familiarity with this standard related to a frontier or remote area, as opposed to the characterization of a rural area as proposed above, we provide the following background. The Economic Research Service within the United States Department of Agriculture has developed ZIP-code-level FAR designations, where the phrase frontier and remote is used to describe territory characterized by some combination of low population size and high geographic remoteness. The most updated set of FAR codes is based on urban-rural data from the 2010 decennial census and provides four FAR definition levels, ranging from one that is relatively inclusive (12.2 million FAR level one residents) to one that is more restrictive (2.3 million FAR level four residents). FAR areas are defined in relation to the time it takes to travel by car to the edges of nearby urban areas, and four FAR levels are necessary because rural areas experience degrees of remoteness at higher or lower population levels that affect access to different types of goods and services. For instance, a larger number of people live significant distances from cities providing high order goods and services, such as

advanced medical procedures, stores selling major household appliances, regional airport hubs, or professional sports franchises, and level one FAR codes are meant to approximate this degree of remoteness. A smaller number of people have difficulty accessing low order goods and services, such as grocery stores, gas stations, and basic health-care services, and level-four FAR codes more closely coincide with this higher degree of remoteness. Other types of goods and services—clothing stores, car dealerships, movie theaters—fall somewhere in between. We would use all four levels of FAR codes to characterize remote areas for purposes of these proposed rules.

Consistent with 403(a)(4)(G) of the MISSION Act, proposed § 17.246(a)(7) would implement VA's permissive authority, for purposes of resident placements under PPGMER, to evaluate other criteria that VA considers important in determining those covered facilities that are not adequately serving area veterans. Proposed paragraph (a)(7) would include a non-exhaustive list of criteria VA would consider. Proposed § 17.246(a)(7)(i) would establish that VA may evaluate the proximity of a non-VA covered facility to a VA health care facility, such that residents placed in non-VA covered facilities may also receive training in VA health care facilities. This criterion would be useful in assessing to what extent residents placed in non-VA covered facilities could reasonably be expected to travel to also receive resident training in VA health care facilities, consistent with the requirement that the discretionary criteria in section 403(a)(4)(G) of the MISSION Act relate to identifying those covered facilities that may not be adequately serving area veterans. For purposes of assessing the criterion in proposed § 17.246(a)(7)(i), VA would define a VA health care facility to mean any VA location where VA physicians provide care to Veterans, such as a VA medical center, independent outpatient clinic, domiciliary, nursing home (community living center), residential treatment program, and any of a variety of community-based clinics. We note that this definition is broader than the term "VA facility" under proposed §

17.246(a)(4), as proposed § 17.246 would relate to an independent characterization of the term VA facility under section 401 of Public Law 115-182. We also note that proposed § 17.246(a)(7)(i) does not create any requirement for residents placed under the PPGMER to necessarily rotate to VA facilities to receive training, it is merely one additional criterion that VA may assess in accordance with section 403(a)(4)(G) of the MISSION Act. Any requirement for rotation to VA facilities for residents placed under the PPGMER, like other training requirements for such residents, would be controlled by the agreements formed as will be discussed in the section of this rule that addresses proposed § 17.248. Proposed § 17.246(a)(7)(ii) would establish that VA may evaluate programmatic considerations related to establishing or maintaining a sustainable residency program when determining facilities are not adequately serving area veterans, for purposes of placing residents in covered facilities. These programmatic considerations would include but not be limited to whether the stated objectives of a residency program align with VA's workforce needs; the likely or known available educational infrastructure of a new residency program or existing residency program (including the ability to attract and retain qualified teaching faculty); and the ability of the residency program to remain financially sustainable after the cessation of any financial support from VA that may be furnished under proposed § 17.248. These considerations would allow VA to assess the likelihood of a residency program to be successful and sustainable, thus ensuring VA's resources in funding residents would be well placed to support the PPGMER.

Proposed § 17.246(b) would establish that there would be a prioritized placement of residents under the PPGMER to no fewer than 100 residents for the duration in which the PPGMER is administered in covered facilities operated by either the Indian Health Service, an Indian tribe, a tribal organization, or covered facilities located in the same areas as VA facilities designated by VA as underserved pursuant to criteria developed

under section 401 of Public Law 115-182. This minimum number of residents to be placed in these specific covered facilities is consistent with the requirement in section 403(a)(5) of the MISSION Act. Proposed § 17.246(b) would further clarify that the placement of these 100 residents would be for the duration in which the PPGMER is administered, because we do not read anything in section 403(a)(5) to require these 100 residents to be the first residents placed under this pilot program. We also interpret section 403(a)(5) of the MISSION Act to require VA to consider priority placement of at least 100 residents and not 100 resident positions, which is consistent with a plain reading of section 403(a)(5). We clarify this point because we would define the term resident to permit multiple residents to occupy a single resident position as appropriate. We note that, generally, residents placed through the PPGMER could be at any point in their residency, and that any such placement at any point in a residency would qualify amongst the 100 priority placements in proposed § 17.246.

§ 17.247, Determination process for placement of residents.

We reiterate from earlier in this proposed rule that VA does not interpret that section 403 authorizes a public funding opportunity through which covered facilities or any other entity may apply or submit a proposal to VA, for VA to then consider having residents placed in covered facilities and paying their stipends or benefits, or to reimburse certain costs of new residency programs. The introductory text to proposed § 17.247 would therefore state that section 403 of Public Law 115-182 does not authorize a grant program or cooperative agreement program through which covered facilities or any other entity may apply for residents to be placed in covered facilities or to apply for VA to pay or reimburse costs under § 17.248 (where proposed § 17.248, as discussed later in this rulemaking, would establish VA's payment of resident stipends and benefits, and VA's reimbursement of certain costs of new residency programs). The introductory

text to proposed § 17.247 would further establish that VA will therefore not conduct a public solicitation to determine those covered facilities in which residents may be places or to determine costs that may be paid or reimbursed under § 17.248, but that VA would instead make such determinations based on the parameters further established in proposed § 17.247(a) through (c).

Proposed § 17.247(a) would state that VA Central Office will issue a request for proposal (RFP) to VA health care facilities to announce opportunities for residents to be placed in covered facilities and to have costs paid or reimbursed under § 17.248 (as explained later in this rulemaking, proposed § 17.248 will outline the types of costs available to be paid or reimbursed by VA under the PPGMER.) Proposed § 17.247(a) would further state that the RFP issued by VA Central Office would describe, at a minimum: (1) consideration factors, to include the criteria in § 17.246, that will be used to evaluate any responses to the RFP, as well as the relative importance of such consideration factors; (2) information required to be in any responses to the RFP; and (3) the process to submit a response to the RFP. Under proposed § 17.247(a), the RFP issued by VA Central Office would provide education to VA health care facilities in the evaluation of the factors in proposed § 17.246(a)(1) through (7) to determine clinical need for providers in an area, and the VA health care facilities would then assess covered facilities that may be located in such areas to weigh the factors and determine those covered facilities that meet the criteria under the RFP. We reiterate from earlier in this rulemaking that VA Central Office conducts an RFP process to administer its more general GME programming under section 7302(e), and VA envisions a similar process to be followed under the PPGMER, where VA Central Office notifies VA facilities (directly, or through channels via Veterans Integrated Service Networks) of a forthcoming RFP cycle for the funding of residents or certain resident program costs. The RFP in turn would provide VA health care facilities with all required information to

complete a response, including a clear statement of the consideration factors and submission instructions to include any submission dates as applicable and points of contact for questions. The RFP will additionally provide a general timeline in which VA health care facilities will conduct the process of assessing the consideration factors and reaching out to covered facilities regarding the RFP. The consideration factors in the RFP for the PPGMER would include those consideration factors expressly stated in section 403(a)(4) and in proposed § 17.246, and the relative importance of such factors (e.g., whether they may be weighted differently). We reiterate from earlier in the preamble that the consideration factors in proposed § 17.246 would not be weighted in the regulatory text itself to allow VA the flexibility to consider the relative importance of factors over the duration of the pilot, as the relative importance of those factors may change. For instance, an RFP issued by VA Central Office for the PPGMER could indicate that there would be more weight assigned to areas that issued responses with covered facilities operated by Indian Health Service, an Indian tribe, a tribal organization, or covered facilities located in the same areas as VA facilities designated by VA as underserved, as these are deemed priority placement factors for the PPGMER in section 403(a)(5). Alternatively, an RFP issued by VA Central Office for the PPGMER could indicate that there would be more weight assigned depending on the specialty of a provider included in the most recent staffing shortage determination by VA under 38 U.S.C. section 7412.

Proposed § 17.247(b) would then establish that VA health care facilities, in collaboration with covered facilities, will submit responses to the RFP to VA Central Office. This language would permit only VA health care facilities to submit responses to the RFP issued by VA Central Office, to further reinforce VA's interpretation that section 403 does not authorize a public funding opportunity for which covered facilities may apply directly or submit a proposal to be considered. VA health care facilities would

assess covered facilities in their areas that participate with institutions that sponsor medical educational programs (most often a medical school or teaching hospital), where typically VA already has academic partnerships with such sponsoring institutions and the RFP details the involvement of any particular sponsoring institution. However, VA would not be prevented in these proposed regulations from assessing covered facilities that did not have educational relationships with sponsoring institutions, and covered facilities would not be prevented from initiating contact with a VA facility to determine if such covered facilities may meet the requirements to participate in the PPGMER as detailed in the RFP. We reiterate that the RFP will provide a general timeline in which VA health care facilities will conduct the process of assessing the consideration factors and reaching out to covered facilities regarding the RFP.

Proposed § 17.247(c) would then state that VA Central Office will evaluate responses to the RFP from VA health care facilities and will determine those covered facilities where residents may be placed and costs under § 17.248 are paid or reimbursed. In its evaluation, VA Central Office will assess the consideration factors established in the RFP to include the criteria in § 17.246, and will weigh those factors as their relative importance would be established in the RFP.

§ 17.248, Costs of funding residents and new residency programs.

Proposed § 17.248 would establish the types of costs that VA may fund under the PPGMER to place residents in covered facilities or to reimburse certain costs incurred by new residency programs in accordance with sections 403(a)(6) and (b)(1)-(b)(5) of the MISSION Act. Section 403(a)(6) authorizes VA to pay stipends and provide benefits for residents in positions created under section 403(a)(1), and section 403(b) authorizes VA to reimburse certain new residency program costs if VA places a resident in such a program.

To address a few preliminary matters, we note that section 403(a)(6) is a discretionary authority to pay stipends and benefits of residents, regardless of whether they have been assigned to a VA facility, and that VA would retain this discretion in proposed § 17.248 to include establishing any general restrictions or conditions for such payments. We further interpret the discretionary nature of section 403(a)(6) to authorize VA's funding of resident stipends and benefits either through a direct payment or reimbursement mechanism, in accordance with any contract, agreement, or other arrangement VA has legal authority to form (possibly, to include payment mechanisms as applicable that VA currently uses to administer its more general GME programming under 38 U.S.C. 7302(e)). Conversely, we interpret section 403(b) as a mandatory authority to reimburse certain new resident program costs if VA places a resident in such programs, and further that subsections (b)(1)-(b)(5) establish the mandatory costs that must be reimbursed. However, we do not interpret that section 403(b) limits VA's authority to determine restrictions or criteria for such reimbursement. Lastly, consistent with section 403(a)(3), and other authorities under which VA may legally enter into contracts, agreements, or other arrangements, VA would enter into such contracts, agreements, or other arrangements to administer the PPGMER. It would be those contracts, agreements, or other arrangements that would establish the terms to control costs that could be funded.

The introductory text of proposed § 17.248 would establish that once VA determines in which covered facilities residents will be placed, in accordance with §§ 17.246 through 17.247, payment or reimbursement of certain costs would be authorized. Proposed § 17.248(a) would establish the first category of funding available under the PPGMER, related to resident stipends and benefits, consistent with section 403(a)(6). Proposed § 17.248(a) would establish that, for residents placed in covered facilities by VA, VA may pay only the proportionate cost of resident stipends and

benefits that are associated with residents participating in educational activities directly related to the PPGMER. This language is intended to limit payments of stipend and benefits to only those educational activities that support the PPGMER, to prevent VA's payment for educational activities a resident may complete when they may engage in duties or responsibilities associated with portions of their training not associated with the PPGMER (such as when a resident may have portions of their training paid for by other entities not engaged with the PPGMER). We clarify that educational activities directly related to the PPGMER could be associated with the treatment of non-veteran patients, as section 403(a)(6) of the MISSION Act clearly permits VA to pay stipends and benefits for residents outside of VA facilities, and section 403(b) permits VA to reimburse certain costs associated with new residency programs established in covered facilities, which includes non-VA facilities. More generally, a primary purpose of VA's administration of GME programming under 38 U.S.C. 7302(e), and under section 403 of the MISSION Act by extension, is to fulfill one of VA's missions under 38 U.S.C. 7302 to assist in providing an adequate supply of health personnel to the United States. We reiterate from the discussion of proposed § 17.246(a)(7)(i) that this rule would not create any requirement for residents placed under the PPGMER to necessarily rotate to VA health care facilities to receive training, and any such requirement (as with other training requirements for PPGMER residents) would be controlled by the agreements formed as discussed further in this section of the rule related to proposed § 17.248. Proposed § 17.248(a) would further state that VA's payment of stipends and benefits would be in accordance with any contract, agreement, or other arrangement VA has legal authority to form. In addition, such stipends and benefits will not exceed VA's established maximum amounts for payments under any existing GME agreements. This language intends to establish that any criteria or restrictions related to VA's payment of stipends and benefits would be clearly indicated in contracts, agreements, or other arrangements

outside of the proposed rule. This language would allow VA the flexibility to establish payment parameters as would be relevant to a covered facility, within the appropriate purchasing or other mechanisms that VA may legally use, to include an agreement permitted under section 403(a)(3) of Public Law 115-182. We note that VA would be bound by any legal requirements as they exist outside of this proposed rule with regards to these other authorities to enter into contracts, agreements, or other arrangements. Proposed § 17.248(a) would not state or reference these other authorities, or the resulting payment instruments, however, to provide VA and covered facilities the flexibility that would be needed to properly implement the payment of resident stipends and benefits.

Proposed § 17.248(b) would establish that VA may reimburse certain costs associated with new residency programs, consistent with section 403(b)(1)-(5) of the MISSION Act. Consistent with section 403(b), proposed § 17.248(b)(1) would establish that if a covered facility establishes a new residency program in which VA places a resident, VA will reimburse certain costs as further detailed in proposed § 17.248(b)(1)(i) through (v), where the following costs in proposed paragraphs (b)(1)(i) through (v) mirror the types of costs established in sections 403(b)(1)-(5), which are: curriculum development costs; recruitment and retention of faculty costs; accreditation costs; faculty salary costs; and resident education expense costs. Each of the types of costs established in proposed § 17.248(b)(1)(i) through (v) would be further characterized by the following non-exhaustive examples: (1) curriculum development costs would include but not be limited to costs associated with needs analysis, didactic activities, materials, equipment, consultant fees, and instructional design; (2) recruitment and retention of faculty costs would include but not be limited to costs associated with advertising available faculty positions, and monetary incentives to fill such positions such as relocation costs and educational loan repayment; (3)

accreditation costs would include but not be limited to the administrative fees incurred by a covered facility in association with applying for only initial accreditation of the program by the Accreditation Council for Graduate Medical Education; (4) faculty salary costs would include only the proportionate cost of faculty performing duties directly related to the PPGMER; and (5) resident education expense costs, to include but not be limited to costs associated with the required purchase of medical equipment and required training, national resident match program participation fees, and residency program management software fees. We further note that faculty salary costs in proposed § 17.248(b)(1)(iv) would have a similar qualifying restriction as with resident stipends and benefits in proposed § 17.248(a), where faculty salary costs would be limited to only the proportionate cost of faculty performing duties directly related to the PPGMER. This restriction would provide an express notice that VA would not, for instance, reimburse costs for any portion of salary of an attending physician that correlates with supervising residents that were not participating in the PPGMER, as it may be the case that a group of residents being supervised by an attending physician is not fully comprised of PPGMER participants. Similar to proposed § 17.248(a), proposed § 17.248(b) would further state that VA's reimbursement of certain costs associated with a new residency program would be in accordance with any contract, agreement, or other arrangement VA has legal authority to form, and that reimbursements for authorized costs may not exceed VA's established maximum amounts for payment under any existing GME agreements. This language intends to establish that any criteria or restrictions related to VA's reimbursement of these costs would be clearly indicated in contracts, agreements, or other arrangements outside of the proposed rule, again to allow the flexibility to establish parameters as would be relevant and within the appropriate purchasing or reimbursement mechanisms that VA may legally use. We note that VA would be bound by any legal requirements as exist

outside of this proposed rule with regards to these other authorities to enter into contracts, agreements, or other arrangements, but that proposed § 17.248(b) would not state or reference these other authorities, again to provide VA and covered facilities the flexibility that would be needed to properly implement the reimbursement of these costs.

Although proposed § 17.248(a) and (b) would not state any express criteria or restrictions that might exist in contracts, agreements, or other arrangements that would control the payment of resident stipends or benefits or reimbursement of certain new residency program costs, some examples of such criteria or restrictions could include: establishing a discontinuation date for payments or reimbursements; establishing limitations on payments proportionate to the number of residents placed by VA; establishing any fixed dollar amount limits as found relevant or appropriate; or establishing a restricted look-back period, whereby VA would not reimburse the costs of, for instance, certain curriculum development costs that might occur prior to a specified timeframe before VA places a resident. Similarly, proposed § 17.248(a) and (b) would not expressly list the legal authorities or types of contracts, agreements, or other arrangements under which VA may pay resident stipends or benefits, or reimburse certain costs of new residency programs, or more generally to administer other typical aspects of GME programming through the PPGMER. Again, this lack of specificity with regards to identifying specific legal instruments in regulation would allow VA maximum flexibility to administer the PPGMER. However, we reiterate from earlier in this rulemaking that VA would otherwise be bound by any legal requirements as exist outside of this proposed rule with regards to these other authorities to enter into contracts, agreements, or other arrangements. We also reiterate from earlier in this rulemaking that VA would seek to administer the PPGMER in much the same manner as VA's more general GME programming is administered under 38 U.S.C. 7302(e), as would be applicable and permissible, which would likely include the forming of certain

agreements between VA and sponsoring institutions to establish responsibilities for educating residents and to control VA's funding of residents and certain costs of new residency programs, or the evidence that such agreements were formed between sponsoring institutions and non-VA covered facilities. We therefore provide the following examples of types of agreements VA uses to administer its more general GME programming under section 7302(e), to provide some idea of whether the same or similar instruments might also be used to administer the PPGMER. Under VA's more general GME programming pursuant to 38 U.S.C. 7302(e), VA uses an affiliation agreement to delineate the duties and responsibilities regarding the training of residents, where an affiliation agreement is a central part of the relationship between VA and the affiliated institution and may involve specific provisions related to patient care, education, or research. Affiliated institutions can include academic institutions and other sponsoring institutions such as community hospitals, clinics, state agencies military treatment facilities, or Federal Health Education Consortia. VA would look to an affiliation agreement or similar instrument to form similar relationships with entities to administer the PPGMER. We note that VA policy currently recognizes sponsoring institutions and other entities as able to enter into an affiliation agreement prior to a subject residency program receiving comprehensive or full accreditation, such as an institution whose residency program may have some stage of Accreditation Council for Graduate Medical Education (ACGME) initial or provisional accreditation. See VHA Handbook 1400.03, Veterans Health Administration Educational Relationships. Under the PPGMER, we would retain VA's ability to enter into affiliation agreements or similar instruments or look to the formation of such instruments between sponsoring institutions and non-VA covered facilities, where the subject residency programs may have some form of initial or provisional ACGME accreditation.

Under VA's more general GME programming pursuant to 38 U.S.C. 7302(e), a disbursement agreement is used to administer stipend and benefits payments to residents in VA facilities. A disbursement agreement is an agreement through which VA allows a disbursing agent to administer salary payments and fringe benefits for medical residents assigned to a VA facility, where the disbursing agent may be the sponsoring institution for the residency training program itself or an entity delegated by the sponsoring institution(s) to handle stipend and benefit disbursements (e.g., a graduate medical education consortium). VA may look to a similar instrument to administer stipend and benefits payments for residents it places in non-VA facilities under the PPGMER, or any other contract, agreement, or other arrangement VA may enter into as permissible and applicable.

Under VA's more general GME programming pursuant to 38 U.S.C. 7302(e), VA uses educational cost contracts to pay pro-rated educational costs of the affiliated institutions sponsoring residency programs. These educational cost contracts are entered into pursuant to 38 U.S.C. 8153, where the relevant health care resource being purchased includes health care support resources and administrative resources to include the operation of a residency program. The pro-rated educational costs to be covered are set forth in an educational cost contract in proportion to the number of residents that actually rotate to a VA facility. VA may look to a similar instrument to administer payments of costs associated with the PPGMER, or any other contract, agreement, or other arrangement VA may enter into as permissible and applicable.

VA also generally uses memoranda of agreement or understanding (MOA or MOU) as legally permissible to enter into agreements with entities and may look to such instruments to administer payments of costs associated with the PPGMER or to administer other aspects of the PPGMER. For instance, a MOA or MOU might be used to clearly indicate to a covered facility the extent of reimbursable costs allowable under

proposed § 17.248(b), and could also include instructions for submitting to VA invoices of such costs and timeframes and modes of reimbursement.

Proposed § 17.248(b)(2) would lastly establish that VA considers new residency programs as only those residency programs that have initial ACGME accreditation or have continued ACGME accreditation without outcomes, and have not graduated an inaugural class, at the time VA has determined those covered facilities where residents will be placed under § 17.247(c). We believe the ACGME status of initial accreditation or continued ACGME accreditation without outcomes captures those residency programs still in development and that would benefit from VA's reimbursement of certain start-up costs in establishing a residency program. The additional criterion that such programs must not have graduated an inaugural class further supports that VA funding will not go to residency programs that otherwise have fully functioning curriculums and infrastructure to produce graduates. The ACGME status of initial accreditation is considered a developmental stage where residency programs can accept residents, and this status allows for site visits to determine compliance with relevant ACGME standards. As background, when a status of initial accreditation is conferred on a sponsoring institution or program, that institution or program will have a full site visit within two years of the effective date of initial accreditation, where the effective date is the date of the decision by the ACGME review committee (or, any effective date such committee may apply retroactively to the beginning of the academic year). If a residency program does not matriculate residents in the first academic year after receiving a status of initial accreditation, a site visit is conducted within three years from the effective date of such accreditation. If a sponsoring institution or program demonstrates substantial compliance at the subsequent review, the ACGME review committee may confer a status of continued accreditation or continued accreditation without outcomes. Proposed § 17.248(b)(2) would only include the ACGME status of

continued accreditation without outcomes, beyond the initial accreditation stage, because continued accreditation without outcomes indicates that no residents have graduated, which in turn may indicate that the residency program still requires VA funding of certain costs to fully develop its curriculum and infrastructure.

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. The Office of Information and Regulatory Affairs has determined that this rule is a significant regulatory action under Executive Order 12866. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at www.regulations.gov.

Consultation and Coordination With Indian Tribal Governments

We have analyzed this proposed rule in accordance with the principles set forth in Executive Order 13175. We have tentatively determined that the rule does not contain policies that would have a substantial direct effect on one or more Indian Tribes, on the relationship between the Federal Government and Indian Tribes, or on the distribution of power and responsibilities between the Federal Government and Indian Tribes. The Agency solicits comments from tribal officials on any potential impact on Indian Tribes from this proposed action.

Regulatory Flexibility Act

The Secretary hereby certifies that this rulemaking would not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601-612. The residents to be placed for training in covered facilities and to have certain stipend and benefits costs paid for by VA are individuals and not small entities. To the extent that any covered facilities are small entities, there is no significant economic impact because the rulemaking would only permit VA's reimbursement and not payment of certain costs associated with certain start up costs associated with new residency programs, there is no funding opportunity for which covered facilities may apply to be considered and otherwise no economic gain or loss for covered facilities associated with this rule. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This proposed rule would have no such effect on State, local, and tribal governments, or on the private sector.

Paperwork Reduction Act

The Paperwork Reduction Act of 1995 (44 U.S.C. 3507) requires that VA consider the impact of paperwork and other information collection burdens imposed on

the public. Except for emergency approvals under 44 U.S.C. 3507(j), VA may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. This proposed rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3521).

Assistance Listing

The Assistance Listing program numbers and titles for the programs affected by this document are 64.011 - Veterans Dental Care; 64.026 - Veterans State Adult Day Health Care; 64.040 - VHA Inpatient Medicine; 64.041 - VHA Outpatient Specialty Care; 64.042 - VHA Inpatient Surgery; 64.043 - VHA Mental Health Residential; 64.045 - VHA Outpatient Ancillary Services; 64.046 - VHA Inpatient Psychiatry; 64.047 - VHA Primary Care; 64.048 - VHA Mental Health clinics; 64.050 - VHA Diagnostic Care; 64.054 - Research and Development.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs-health, Grant programs-veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved this document on October 8, 2021, and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs.

***Consuela Benjamin**,*

Regulations Development Coordinator,
Office of Regulation Policy & Management,
Office of General Counsel,
Department of Veterans Affairs.

For the reasons stated in the preamble, the Department of Veterans Affairs proposes to amend 38 CFR part 17 as follows:

PART 17 – MEDICAL

1. Amend the authority citation for part 17 by adding an entry for §§ 17.243 through 17.248 in numerical order to read in part as follows:

Authority: 38 U.S.C. 501, and as noted in specific sections.

* * * * *

Sections 17.243 through 17.248 are also issued under 38 U.S.C. 7302 note.

* * * * *

2. Add an undesignated center heading and §§ 17.243 through 17.248 to read as follows:

VA Pilot Program on Graduate Medical Education and Residency

Sec.

VA Pilot Program on Graduate Medical Education and Residency

§ 17.243 Purpose and scope.

(a) *Purpose*. This section and §§ 17.244 through 17.248 implement the VA Pilot Program on Graduate Medical Education and Residency (PPGMER), which permits placement of residents in existing or new residency programs in covered facilities and permits VA to reimburse certain costs associated with establishing new residency programs in covered facilities, as authorized by section 403 of Public Law 115-182.

(b) *Scope*. This section and §§ 17.244 through 17.248 apply only to the PPGMER as authorized under section 403 of Public Law 115-182, and not to VA's more

general administration of graduate medical residency programs in VA facilities as authorized under 38 U.S.C. 7302(e).

§ 17.244 Definitions.

For purposes of §§ 17.243 through 17.248:

Benefit means a benefit provided by VA to a resident that has monetary value in addition to a resident's stipend, which may include but not be limited to health insurance, life insurance, worker's compensation, disability insurance, Federal Insurance Contributions Act taxes, and retirement contributions.

Covered facility means any facility identified in § 17.245.

Educational activities mean all activities in which residents participate to meet educational goals or curriculum requirements of a residency program, to include but not be limited to: clinical duties; research; attendance in didactic sessions; attendance at facility committee meetings; scholarly activities that are part of an accredited training program; and approved educational details.

Resident means physician trainees engaged in post-graduate specialty or subspecialty training programs that are either accredited by the Accreditation Council for Graduate Medical Education or in the application process for such accreditation. A resident may include an individual in their first post-graduate year (PGY-1) of training (often referred to as an intern), and an individual who has completed training in their primary specialty and continues training in a subspecialty graduate medical education program (generally referred to a fellow).

Stipend means the annual salary paid by VA for a resident.

VA health care facility means any VA-owned or VA-operated location where VA physicians provide care to Veterans, to include but not be limited to a VA medical

center, independent outpatient clinic, domiciliary, nursing home (community living center), residential treatment program, and community-based clinic.

§ 17.245 Covered facilities.

A covered facility is any of the following:

(a) A VA health care facility;

(b) A health care facility operated by an Indian tribe or tribal organization, as those terms are defined in 25 U.S.C. 5304 and at 25 CFR 273.106;

(c) A health care facility operated by the Indian Health Service;

(d) A federally-qualified health center as defined in 42 U.S.C. 1396d(l)(2)(B);

(e) A health care facility operated by the Department of Defense; or

(f) Other health care facilities deemed appropriate by VA.

§ 17.246 Consideration factors for placement of residents.

(a) *General*. When determining in which covered facilities residents will be placed, VA shall consider the clinical need for health care providers in an area, as determined by VA's evaluation of the following factors:

(1) The ratio of veterans to VA providers for a standardized geographic area surrounding a covered facility, including a separate ratio for general practitioners and specialists.

(i) For purposes of paragraphs (a)(1) and (2) of this section, standardized geographic area means the county in which the covered facility is located.

(ii) VA may consider either or both of the ratio(s) for general practitioners and specialists, where a higher ratio of veterans to VA providers indicates a higher need for health care providers in an area.

(2) The range of clinical specialties of VA and non-VA providers for a standardized geographic area surrounding a covered facility, where the presence of fewer clinical specialties indicates a higher need for health care providers in an area.

(3) Whether the specialty of a provider is included in the most recent staffing shortage determination by VA under 38 U.S.C. 7412.

(4) Whether the covered facility is in the local community of a VA facility that has been designated by VA as an underserved facility pursuant to criteria developed under section 401 of Public Law 115-182.

(5) Whether the covered facility is located in a community that is designated by the Secretary of Health and Human Services as a health professional shortage area under 42 U.S.C. 254e.

(6) Whether the covered facility is in a rural or remote area, where:

(i) A rural area means an area identified by the U.S. Census Bureau as rural; and

(ii) A remote area means an area within a zip-code designated as a frontier and remote area (FAR) code by the Economic Research Service within the United States Department of Agriculture, based on the most recent decennial census and to include all identified FAR code levels.

(7) Such other criteria as VA considers important in determining those covered facilities that are not adequately serving area veterans. These factors may include but are not limited to:

(i) Proximity of a non-VA covered facility to a VA health care facility, such that residents placed in non-VA covered facilities may also receive training in VA health care facilities.

(ii) Programmatic considerations related to establishing or maintaining a sustainable residency program, such as: whether the stated objectives of a residency program align with VA’s workforce needs; the likely or known available educational

infrastructure of a new residency program or existing residency program (including the ability to attract and retain qualified teaching faculty); and the ability of the residency program to remain financially sustainable after the cessation of funding that VA may furnish under § 17.248.

(b) *Priority in placements*. For the duration in which the PPGMER is administered, no fewer than 100 residents will be placed in covered facilities operated by either the Indian Health Service, an Indian tribe, a tribal organization, or covered facilities located in the same areas as VA facilities designated by VA as underserved pursuant to criteria developed under section 401 of Public Law 115-182.

§ 17.247 Determination process for placement of residents.

Section 403 of Public Law 115-182 does not authorize a grant program or cooperative agreement program through which covered facilities or any other entity may apply for residents to be placed in covered facilities or to apply for VA to pay or reimburse costs under § 17.248. VA therefore will not conduct a public solicitation to determine those covered facilities in which residents may be placed or to determine costs that may be paid or reimbursed under § 17.248. VA will instead determine those covered facilities in which residents may be placed and determine any costs to be paid or reimbursed under § 17.248 in accordance with the following parameters:

(a) VA Central Office will issue a request for proposal (RFP) to VA health care facilities to announce opportunities for residents to be placed in covered facilities and to have costs paid or reimbursed under § 17.248. This RFP will describe, at a minimum:

(1) Consideration factors to include the criteria in § 17.246, that will be used to evaluate any responses to the RFP, as well as the relative importance of such consideration factors;

(2) Information required to be in any responses to the RFP; and

(3) The process to submit a response to the RFP.

(b) VA health care facilities, in collaboration with covered facilities, will submit responses to the RFP to VA Central Office.

(c) Consistent with paragraph (a) of this section, VA Central Office will evaluate responses to the RFP from VA health care facilities and will determine those covered facilities where residents may be placed and costs under § 17.248 are paid or reimbursed.

§ 17.248 Costs of placing residents and new residency programs.

Once VA determines in which covered facilities residents will be placed in accordance with §§ 17.246 through 17.247, payment or reimbursement is authorized for the following costs:

(a) *Resident stipends and benefits*. For residents placed in covered facilities, VA may pay only the proportionate cost of resident stipends and benefits that are associated with residents participating in educational activities directly related to the PPGMER, in accordance with any contract, agreement, or other arrangement VA has legal authority to form.

(b) *Costs associated with new residency programs*. (1) If a covered facility establishes a new residency program in which a resident is placed, VA will reimburse the following costs in accordance with any contract, agreement, or other arrangement VA has legal authority to form.

(i) Curriculum development costs, to include but not be limited to costs associated with needs analysis, didactic activities, materials, equipment, consultant fees, and instructional design.

(ii) Recruitment and retention of faculty costs, to include but not be limited to costs associated with advertising available faculty positions, and monetary incentives to fill such positions such as relocation costs and educational loan repayment.

(iii) Accreditation costs, to include but not be limited to the administrative fees incurred by a covered facility in association with applying for only initial accreditation of the program by the Accreditation Council for Graduate Medical Education (ACGME).

(iv) Faculty salary costs, to include only the proportionate cost of faculty performing duties directly related to the PPGMER.

(v) Resident education expense costs, to include but not be limited to costs associated with the required purchase of medical equipment and required training, national resident match program participation fees, and residency program management software fees.

(2) VA considers new residency programs as only those residency programs that have initial ACGME accreditation or have continued ACGME accreditation without outcomes, and have not graduated an inaugural class, at the time VA has determined those covered facilities where residents will be placed under § 17.247(c).

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